

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05076

05074

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Smithsburg R # 2 c. LENGTH OF STAY IN b. 22 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cavetown-Boonsboro Pike			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg R # 2 d. STREET ADDRESS Cavetown-Boonsboro Pike e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOHN WESLEY AMBROSE			4. DATE OF DEATH Month Day Year April 22 1962		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2 1888	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days 10 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George L. Ambrose			14. MOTHER'S MAIDEN NAME Emma Hose		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-0904	17. INFORMANT Mrs Emma E. Ambrose Smithsburg R # 2 Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Hypertensive Vascular Disease DUE TO (c) Arterio Sclerosis (generalized) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 yrs 10 yrs					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from March 30, 1962 to April 22 1962 that (I) (we) last saw the deceased alive April 22, 1962 and that death occurred April 22, 1962 from the causes and on the date stated above.					
22a. SIGNATURE G. G. Kohler M.D.			22b. DATE SIGNED April 23 1962		
22c. PHYSICIAN'S NAME (Type) G. A. KOHLER			22d. ADDRESS Smithsburg Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/25/62	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town or county) (State). Hagerstown Wash Co Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.			25a. REC'D BY REGISTRAR APR 26 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kneale		

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 16 6 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) JACKSON CONVALESCENT HOME		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1515 PARK ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA MAE ANGLE		4. DATE OF DEATH Month APRIL Day 4 Year 19 62	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 15 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) FRANKLIN PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME COMMODORE F LOWMAN		14. MOTHER'S MAIDEN NAME MARGARET YOUNG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS MAE ANGLE HAGERSTOWN MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ----- 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) ----- 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) 20f. (City or town) (County) (State) -----			INTERVAL BETWEEN ONSET AND DEATH 3 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from 5-25-61 , 19 death , that (I) (we) last saw the deceased alive on 4-1-62 , 19 death , and that death occurred 4:10AM from the causes and on the date stated above.			
22a. SIGNATURE Paul Harrison (Robert F. Keadle) RFK M.D.		22b. DATE SIGNED 4-1-62	
22c. PHYSICIAN'S NAME (Type) PAUL HARRISON M. D.		22d. ADDRESS 318 N POTOMAC ST. HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-6-62	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE Charles M. Rouzer SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR APR 10 '62	25b. REGISTRAR'S SIGNATURE Charles S. Thane

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 Film G312 5/8/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in 1b <u>Month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland MD</u> d. STREET ADDRESS <u>539 Columbia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES Otha BAGENT</u> First Middle Last 4. DATE OF DEATH <u>APRIL 29 - 1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1888 March 3, 1887</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>Jacob H. Bagant</u> 14. MOTHER'S MAIDEN NAME <u>Anna Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-05-5714</u> 17. INFORMANT <u>Mrs. Charles O. Bagant</u> Address <u>Cumb. MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>generalized metastasis</u> DUE TO (c) <u>carcinoma of prostate</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>unknown</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-6-62</u> , 19 <u>62</u> , to <u>4-29</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-29</u> , 19 <u>62</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos,</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. Ramos, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. ADDRESS <u>1500 Pa Ave Hagerstown MD</u> 22d. DATE SIGNED <u>April 30, 1962</u>	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/3/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memo. Pk.</u> 23d. LOCATION (City, town or county) (State) <u>Cumberland MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. MD.</u> 25a. REC'D BY REGISTRAR <u>MAY 3 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR AIS (4)
15M 7/61

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
05079						05077							
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
a. COUNTY			Washington			a. STATE			b. COUNTY				
			MARYLAND						Washington				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)							
Hagerstown			7 Months			X Rural Hagerstown							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Western Md. State Hospital						1 Route 5							
3. NAME OF DECEASED (Type or print)			First			Middle			Last				
			SUSAN			-----			BARBER				
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH				
Female			White			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			July 4, 1874				
9. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.							
87 yrs.			Months Days			Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
House Wife			Own Home			Adams Co. Pa.							
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME							
Leonard Wyssinger						Mary Long							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT	
No						-----						Mrs. Simon Summers	
												Hag. Rt. 5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANEURISM OF THE ABDOMINAL AORTA - RUPTURED 451X DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) GENERALIZED ATHEROSCLEROSIS (e), stating the underlying cause last. DUE TO (c) UNKNOWN													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
SUBACUTE AND CHRONIC PYELONEPHRITIS													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town) (County) (State)													
21. I certify that (I) (the hospital) attended the deceased from 10-19-62, to 4-28-62, that (I) (we) last saw the deceased alive on 4-28-1962, and that death occurred at 9:15 AM, from the causes and on the date stated above.													
22a. SIGNATURE													
Antonio U. Palladrosi M.D.													
22b. ADDRESS													
1500 Pa Ave Hagerstown MD													
22c. PHYSICIAN'S NAME													
ANTONIO U. PALLADROSI													
23a. BURIAL, CREMATION, REMOVAL (Specify)													
Burial													
23b. DATE THEREOF													
5-1-62													
23c. NAME OF CEMETERY OR CREMATORY													
Shiloh U. B. Cemetery													
23d. LOCATION (City, town or county) (State)													
Fiddlersburg. Md.													
24. FUNERAL DIRECTOR'S SIGNATURE													
Scott F. Minnich & Son													
Hagerstown, Md.													
25a. REC'D BY REGISTRAR													
DATE MAY 2 '62													
25b. REGISTRAR'S SIGNATURE													
Arthur S. Kraus													

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WEST COAST OF AFRICA

Western Dr. Spence-Hopland

London

Only 8, 1925

James Col. Dr.

REPORTED RESEARCHER

Only 1925

Dr. Simon Summer

Scott E. Finnish & Son, Lagos, N. I.

Simon E. Finnish & Son, Lagos, N. I.

Lagos, N. I.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05080
CERTIFICATE OF DEATH
05078

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEWSVILLE c. LENGTH OF STAY IN 1b 18 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NO STREET ADDRESS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEWSVILLE d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIE SEIBERT BECK		4. DATE OF DEATH Month Day Year APRIL 4 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 31 1872
9. AGE (In years last birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER	
11. BIRTHPLACE (County & State, or foreign country) FRANKLIN PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME CONRAD SEIBERT		14. MOTHER'S MAIDEN NAME BARBARA FRIESE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS JOHN W CABLE JR CHEWSVILLE MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-1-1962 to 4-4-1962 , that (I) (we) last saw the deceased alive on 4-3-1962 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE E.W.DITTO JR. M. D.		22b. DATE SIGNED APRIL 6 1962	
22c. PHYSICIAN'S NAME (Type) E.W.DITTO JR. M. D.		22d. ADDRESS 215 W WASHINGTON ST. HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-6-62	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR APR 10 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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CENTRAL OF GEORGIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05081					05079									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY Washington MARYLAND					a. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Mt. Airy 10X-2									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Md. State Hospital					d. STREET ADDRESS RD#3, Penn Shop Rd.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED					4. DATE OF DEATH									
(Type or print) Arville Bridges					Month April Day 14 Year 1962									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1881		9. AGE (In years last birthday) 81 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Buildings		11. BIRTHPLACE (County & State, or foreign country) Campbell Co., Tenn.		12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME William H. Bridges					14. MOTHER'S MAIDEN NAME Catherine Foust									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. 214-16-1484					17. INFORMANT Mr. Ollie Bridges, New Market, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia, bilateral										3 days				
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.										(b) cerebro-vascular accident				
										(c) general arteriosclerosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from April 18, 1962 to April 14, 1962 that (I) (we) last saw the deceased alive on April 14, 1962 , and that death occurred at 9:15 AM , from the causes and on the date stated above.														
22a. SIGNATURE Victor L. Ramos, M.D.										22b. DATE SIGNED April 14, 1962				
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.										22d. ADDRESS Western Md. State Hospital Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 4/17/62				
23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.										23d. LOCATION (City, town or county) (State) Clagettville, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Wicksunth										25a. REC'D BY REGISTRAR April 18 '62				
ADDRESS Damascus, Md.										25b. REGISTRAR'S SIGNATURE Charles S. Kline				

1902

CERTIFICATE OF DEATH

03079

Washington

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Washington State Hospital

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William B. Bridges

Catherine Jones

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FOR STATE
HEALTH DEPT.
M
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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05080									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 57 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 1 27 N. Locust			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Clayton Carper					4. DATE OF DEATH April 14 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 29, 1897		9. AGE (In years last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Store		11. BIRTHPLACE (State or foreign country) White Post, Va.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Albert Carper					14. MOTHER'S MAIDEN NAME Elizabeth Grubbs				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-0805		17. INFORMANT Mrs. Dorothea C. Carper Hag. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 <u>Coronary Occlusion</u> DUE TO <u>Pulmonary Congestion & Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Atherosclerosis, Severe</u> DUE TO (c) <u>Cardiac Hypertrophy</u>								INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 14, 1962 EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-62		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown, Md.			
23. FUNERAL DIRECTOR Scott F. Minnich & Son Hagerstown, Md.					24a. REC'D BY REGISTRAR DATE APR 17 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Krauss		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05083
CERTIFICATE OF DEATH
05081

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 357 Ridge Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE ELVIN CONDON		4. DATE OF DEATH Month Day Year April 23 1962 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25 1898
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (Country, State, or foreign country) Franklin Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Condon		14. MOTHER'S MAIDEN NAME Nora Sease	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-5886	
17. INFORMANT Mrs Pauline V. Condon		Address 357 Ridge Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① general arteriosclerosis - ② prostate hypertrophy, benign		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 25, 1960 to Apr 23, 1962 that (I) (we) last saw the deceased alive on Apr 22, 1962 and that death occurred at 5:22 M, from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III M.D.		22b. DATE SIGNED APR 26 '62	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto 111, M.D.		22d. ADDRESS 217 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/62	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR APR 26 '62	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

05083

05083

DATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Hagerstown RFD #3</u> d. STREET ADDRESS <u>Sharpsburg Pike</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mary Hetzer Downey</u>						4. DATE OF DEATH <u>April 30 19 62</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Park Head Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Charles Hetzer</u>						14. MOTHER'S MAIDEN NAME <u>Anna Moore</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Sharpsburg Pike</u> <u>Mr. George B. Downey Hagerstown RFD 3 Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Traumatic Ruptures, (Two) First Part Of Jejunum</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute Generalized Peritonitis</u> DUE TO <u>Multiple Bony Fractures: Left Ilium Right</u> (c) <u>Patella</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Incollision with another car Sharpsburg Pike 1 mile South Of Hagerstown.</u>							
20c. TIME OF INJURY Month, Day, Year <u>7:30 p.m. 4-28-62 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sharpsburg Pike</u>		20f. (City or town) <u>Hagerstown, Washington, Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>May 1, 1962</u>		
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>May 2-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR <u>Albert Leaf Williamsport, Md</u>						24a. REC'D BY REGISTRAR <u>MAY 3 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Hanna</u>			

MEDICAL CERTIFICATION

STATE OF
NEW YORK

(M)

40081

0-008

IN SENATE
January 1, 1908
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1907
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05085

05083

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland Washington b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 1 Marbern Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marbern Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROY Middle MADISON Last EASTERDAY				4. DATE OF DEATH Month April Day 29 Year 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 30, 1876	
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Martin V. Easterday			
14. MOTHER'S MAIDEN NAME Susan Palmer				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 214-09-3826				17. INFORMANT Address Mrs. Margaret Ruth, Marbern Road, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 692.4 DUE TO Abscesses, multiple, right leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 months 2 months.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease, cerebral arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-24-62 to death , 19....., that (I) (we) last saw the deceased alive on 4-28-1962 and that death occurred at 6:00 AM from the causes and on the date stated above.							
22a. SIGNATURE Robert F. Keadle M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		4-30-62 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle				22d. ADDRESS 318 North Potomac Street, Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 1, 1962		23c. NAME OF CEMETERY OR CREMATORY Rest Haven		23d. LOCATION (City, town or county) (State) Hagerstown Wash. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle, Myersville, Md.				25a. REC'D BY REGISTRAR MAY 2 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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September 30, 1976

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Harold V. Carpenter

Queen Farmer

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Carolina

Association, multiple, plant

Washington State, Central Washington

Robert P. Smith

Parted May 1, 1962 from Haven

Paul T. Little, Knoxville, Md.

Washington State, Co. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1 (M)

DR LIE VAN

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05086

05084

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROHRERSVILLE</u> c. LENGTH OF STAY IN <u>75 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MAIN ST.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROHRERSVILLE</u> d. STREET ADDRESS <u>MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALBERTA EASTON</u>				4. DATE OF DEATH <u>APRIL 4 - 1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 9, 1877</u>	
9. AGE (in years last birthday) <u>85 yrs.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>25</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>PARK HALL WASH. CO. MD. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JOHNY REEDER</u>				14. MOTHER'S MAIDEN NAME <u>MALINDA DICK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS. GROVER DORMAN HAGERSTOWN MD. R. 3</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>Unrecognized arteriosclerosis</u> DUE TO (b) <u>fracture of right hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs. 1 wk.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10, 1961</u> , to <u>4-4, 1962</u> , that (I) (we) last saw the deceased alive on <u>4-2, 1962</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Luedan</u> M.D.				22b. DATE SIGNED <u>4/6/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. W. Luedan</u>				22d. ADDRESS <u>Boonsboro, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 7 - 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROHRERSVILLE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>ROHRERSVILLE WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u> ADDRESS <u>BOONSBORO MD.</u>				25a. REC'D BY REGISTRAR <u>APR 11 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

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00088

RECEIVED

00088

1

Handwritten notes and signatures, including "J. H. H."

Handwritten notes and signatures, including "J. H. H." and "J. H. H."

1
FOR STATE
HEALTH DEPT.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05087 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05085

1. PLACE OF DEATH e. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 640 Summit Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lewis Middle Markell Last Eberly			4. DATE OF DEATH Month April Day 29 Year 19 62		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1962		9. AGE (In years last birthday) yrs. 2 Months 13 Days 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Frank Eberly			14. MOTHER'S MAIDEN NAME Norma Jean Neff		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. ----		17. INFORMANT Frank Eberly Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTERSTITIAL PNEUMONIA 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pulmonary congestion and edema DUE TO (c) Gastro-enteritis, nonspecific					INTERVAL BETWEEN ONSET AND DEATH Recent
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) E. W. DITTO, JR., M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) 4-30-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-30-62	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR Scott F. Minnich & Son Hagerstown, Md.			24a. REC'D BY REGISTRAR MAY 2 '62		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>

2-002509

FOR STATE
DEPT. FILE

(M)

65082

WARRANTED STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Hopkinton

Haystack

240 South Ave.

Lewis

Marshall

Burley

Miss

Jones

Jones

Haystack, Md.

Franklin

Marion Jean York

1000 1/2 South Ave. Haystack, Md.

INVESTIGATIONAL PATHOLOGY

Pulmonary congestion and edema

Gastro-intestinal, non-specific

X

X

X

1-30-32

U. S. DEPT. OF HEALTH

1-30-32

Post Mortem Examination

Haystack, Md.

George E. Smith & Son, Haystack, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
05088										
CERTIFICATE OF DEATH										
Reg. Dist. No. 05086										
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MYERSVILLE 10x-2					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD E. FRANKLIN					4. DATE OF DEATH Month Day Year 4 1 1962					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/1884		9. AGE (In years lost birthday) 77 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ??		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) WASHINGTON COUNTY, MD.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles F. Downs					14. MOTHER'S MAIDEN NAME Anna R. Pierce					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT HOWARD L. DOWNES			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO NEPHROSCHLEROSIS WITH UREMIA Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCHLEROSIS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO INTERVAL BETWEEN ONSET AND DEATH 6 MO. 1 YR.										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/12/62 to 4/1/62, that I last saw the deceased alive on 4/1/62, and that death occurred at 4:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 832 POTOMAC AVE. DATE SIGNED ACTUAL SIGNATURE Jacob G. Warden, M.D. PHYSICIAN'S NAME (Type) JACOB G. WARDEN, M.D. HAGERSTOWN, MARYLAND										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/62		22c. NAME OF CEMETERY OR CREMATORY Grantsville Cem.			22d. LOCATION (City, town, or county) (State) Grantsville Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. R. Konhaus					ADDRESS Meersdale, Pa.		24a. REC'D BY REGISTRAR DATE APR 9 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hester	

CERTIFICATE OF DEATH

1922



W. S. LITTLE E. FRANKLIN F. EDERIC

W. S. LITTLE 20 DAYS W. S. LITTLE

WASHINGTON COUNTY HOSPITAL

RICHARD E. FRANKLIN 77 77 1 1 2

WASHINGTON COUNTY, MD. US

HOWARD L. DOWLES

LEONARD L. DOWLES 212 VIT. U.S. 1
LEONARD L. DOWLES 212 VIT. U.S. 1

312 312 312 312 312 312 312 312 312 312

J. COOPER, WARDEN, D.D. H. L. LITTLE, BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05089											
05087											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Homewood Church Home						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 21 East Antietam Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last LAURA ELLEN FUNK						4. DATE OF DEATH Month Day Year April 24, 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1866		9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) St. James Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Solomon Funk						14. MOTHER'S MAIDEN NAME Catherine Rowland					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Williamsport, Md. Homewood Church Home Records,					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cerebral Hemorrhage DUE TO Cerebral Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. General arterio-sclerosis DUE TO General arterio-sclerosis										INTERVAL BETWEEN ONSET AND DEATH 1 wk Yes Yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from any , 19 60 , to 4/24 , 19 62 , that (I) (I) last saw the deceased alive on 9/21 , 19 60 , and that death occurred at 6 M, from the cause and on the date stated above.											
22a. SIGNATURE Louis G. Graff M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/25/62			
22c. PHYSICIAN'S NAME (Type) Louis G. GRAFF						22d. ADDRESS 119 E. Antietam Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/26/62		23c. NAME OF CEMETERY OR CREMATORY Zion E&R Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Maryland						ADDRESS		25a. REC'D BY REGISTRAR APR 26 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05090

05088

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Point d. STREET ADDRESS 08X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Richard Gooseberry First Middle Last 4. DATE OF DEATH 4 20 1962 Month Day Year		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH January 1, 1904 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman (Waterman) 10b. KIND OF BUSINESS OR INDUSTRY Oyster Business 11. BIRTHPLACE (County & State, or foreign country) Charles County, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Goosberry 14. MOTHER'S MAIDEN NAME Mary Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 213-16-2823 17. INFORMANT Mrs. Margaret E. Goosberry-Wife-Rock Point, Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. 150X DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH one year 4 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 29, 1962 to April 20, 1962 that (I) (we) last saw the deceased alive on April 20, 1962 and that death occurred at 8:02 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D. 22b. DATE SIGNED 4/20/1962		22c. PHYSICIAN'S NAME (Type) YOUNG E CHUN 22d. ADDRESS 1500 Penna Ave Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/24/1962 23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery 23d. LOCATION (City, town or county) Issue, Maryland		25a. REC'D BY REGISTRAR APR 25 '62 25b. REGISTRAR'S SIGNATURE Arthur E. Thomas	
24. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, Inc. - La Plata, Md. ADDRESS			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05091 CERTIFICATE OF DEATH 05089

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EAKLES MILL</u> c. LENGTH OF STAY IN 1b <u>10 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KEEDYSVILLE MD. R.I.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EAKLES MILL - RURAL</u> d. STREET ADDRESS <u>KEEDYSVILLE MD. R.I.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ADAM E. GREEN</u> First Middle Last 4. DATE OF DEATH <u>APRIL - 14 - 1962</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JANUARY - 2 - 1892</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>3</u> <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARM LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MYERSVILLE FRED CO. MD U.S.A.</u> 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>SAMUEL GREEN</u> 14. MOTHER'S MAIDEN NAME <u>MARGARET HOLMES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>215-18-1074</u> 17. INFORMANT <u>MRS. LULA S. GREEN</u> Address <u>KEEDYSVILLE MD. R.I.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intermittent Head with</u> <u>4-20-62</u> DUE TO (b) <u>decompensation -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>1 hour</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>10:10</u> to <u>April 14</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 14</u> , 19 <u>62</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>G.W. Ledan</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/16/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.W. Ledan</u>		22d. ADDRESS <u>Boonsboro Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL - 17 - 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MT. LENA WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Bast</u> ADDRESS <u>Boonsboro MD</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u> DATE 25b. REGISTRAR'S SIGNATURE <u>C. L. S. Kraw</u>	

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05092 CERTIFICATE OF DEATH 05090

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 5 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Maryland State Hosp.		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1019 Corbett St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jesse Franklin Greene		4. DATE OF DEATH Month April Day 1 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Hag. Gas Co.	
11. BIRTHPLACE (County & State, or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Greene		14. MOTHER'S MAIDEN NAME Susan Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no --		16. SOCIAL SECURITY NO. 317-09-2691A	
17. INFORMANT Mrs. Virginia Corsi Address 401 S. Potomac St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, bil. DUE TO (b) cerebro-vascular accident DUE TO (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) (1) cerebro-vascular accident, old c hemiparesis (2) Hypertensive cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 5 days 9 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 19, 1961 to April 1, 1962 that (I) (we) last saw the deceased alive on April 1, 1962 , and that death occurred at 12:30 from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED April 1, 1962	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE APR 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

(M)

03003

03003

CERTIFICATE OF DEATH

State of New York

County of ...

I, the undersigned, a Justice of the Peace in and for the County of ...

do hereby certify that ...

This death occurred on the ... day of ...

at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

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at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

at the residence of the deceased, ...

THE STATE
HEALTH DEPT.

(M)

02003

10001

SHOCK DUE TO MASSIVE BLEED IN D. M. LEE
FRACTURED KNEE-FRACTURED LEFT ARM
2 LEFT LEG.

PATIENT FIED ENROUTE BY AIRPLANE ON WAY TO CHICAGO, ILL.
W. SHINGT N. D. C.

STUCK HEAD IN BY CAR COMING IN REVERSE
274 BLVD. N. W. ST. L. MO. 64108
X RT. AND, GR. HTSVILL, MO.

2:00 PM 1-20

X

X

X

DR. E. W. LITTLE, JR.

4-20-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05094

05092

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 26 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1241 Potomac Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anthea Middle Ruth Last Hankey		4. DATE OF DEATH Month April Day 14 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1917 9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) assembler		10b. KIND OF BUSINESS OR INDUSTRY aircraft mfg. 11. BIRTHPLACE (County & State, or foreign country) Somerset, Penna. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ira R. Barron		14. MOTHER'S MAIDEN NAME Anna Baltzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war and dates of service)		16. SOCIAL SECURITY NO. 214-09-8783 17. INFORMANT Address Wm. L. Hankey, Jr., Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Chronic pyleonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Cardiac Hypertension R. L.L. Pneumonia (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) - (County) - (State) -
21. I certify that (I) (this hospital) attended the deceased from July 1961 , to Apr. 14, 1962 , that (I) (we) last saw the deceased alive on Apr. 14, 1962 , and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Harold R. Tritch Jr M.D.		22b. DATE SIGNED 4-16-62	
22c. PHYSICIAN'S NAME (Type) Harold R. Tritch, Jr. MD		22d. ADDRESS 302 N. Potomac St-Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 4-17-62	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City, town or county) Hagerstown, Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md. ADDRESS		25a. REC'D BY REGISTRAR APR 18 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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Spoke

1000

1970-1971

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05093

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Sharpsburg		c. LENGTH OF STAY IN lb 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X (Rural) Sharpsburg		d. STREET ADDRESS Sharpsburg RFD #1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sharpsburg On RFD #34		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Donald		First		Middle Alvin		Last Helman Jr.	
4. DATE OF DEATH April		Month 8		Day 1962		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 8 1942	
9. AGE (In years last birthday) 19		IF UNDER 1 YEAR Months 4 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Filling Station		11. BIRTHPLACE (State or foreign country) Mercersburg Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Donald Alvin Helman Sr.		14. MOTHER'S MAIDEN NAME Anna Virginia Yeager					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 215-42-3778		17. INFORMANT Mr. J. Edgar Churchey		Address Sharpsburg RFD #1 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull 819 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Struck abutment of underpass R# 34, 2 mile West of Sharpsburg, Md.					
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 4-8-1962		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X State R # 34		20f. (City or town) (County) (State) Sharpsburg, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE J. E. W. Ditto, Jr.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-9-62	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11-62		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or country) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR Albert L. Lee Williamsport, Md.		ADDRESS		24a. REC'D BY REGISTRAR APR 12 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



requires that the death certificate be ex-
amined by the attending physician and
physician.
d within 24 hours after
the funeral

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05096

05094

1. PLACE OF DEATH a. COUNTY <div style="text-align: center; font-size: 1.2em;">WASHINGTON</div> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">HAGERSTOWN</div> c. LENGTH OF STAY in 1b <div style="text-align: center; font-size: 1.2em;">3 WEEKS</div> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">WASH. CO. HOSPITAL</div>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <div style="text-align: center; font-size: 1.2em;">MARYLAND</div> b. COUNTY <div style="text-align: center; font-size: 1.2em;">WASHINGTON</div> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">03 HAGERSTOWN</div> d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">22 SOUTH POTOMAC ST.</div>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center; font-size: 1.2em;">GRACE-LINNIE - HELSER</div>		4. DATE OF DEATH Last Month Year <div style="text-align: center; font-size: 1.2em;">APRIL - 27 - 1962</div>	
5. SEX <div style="text-align: center; font-size: 1.2em;">FEMALE</div>	6. COLOR OR RACE <div style="text-align: center; font-size: 1.2em;">WHITE</div>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">MARCH 11, 1901</div>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">WAITRESS</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-size: 1.2em;">DEVON HOTEL</div>	
11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center; font-size: 1.2em;">OAK GROVE PENNA. U.S.A.</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">U.S.A.</div>	
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">ABRAHAM HELSER</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">ADDIE DALE</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <div style="text-align: center; font-size: 1.2em;">No.</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 1.2em;">220-16-3741</div>	
17. INFORMANT Address <div style="text-align: center; font-size: 1.2em;">MRS. LEROY HARTRANFT</div>		<div style="text-align: center; font-size: 1.2em;">523 SALEM AVE. HAGERSTOWN MD.</div>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="text-align: center; font-size: 1.2em;">420.1</div> DUE TO Conditions, if any, which gave rise to immediate cause (b) <div style="text-align: center; font-size: 1.2em;">Corynebacterium</div> DUE TO (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <div style="text-align: center; font-size: 1.2em;">19</div>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <div style="text-align: center; font-size: 1.2em;">3/3 1962 3/27/62</div>	
21. I certify that (I) (this hospital) attended the deceased from <div style="text-align: center; font-size: 1.2em;">3/3/62</div> to <div style="text-align: center; font-size: 1.2em;">3/27/62</div> that (I) (we) last saw the deceased alive on <div style="text-align: center; font-size: 1.2em;">1962</div> and that death occurred at <div style="text-align: center; font-size: 1.2em;">M</div> from the causes and on the date stated above.			
22a. SIGNATURE <div style="text-align: center; font-size: 1.2em;">JTB</div>		22b. DATE SIGNED <div style="text-align: center; font-size: 1.2em;">3/27/62</div>	
22c. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">JTB</div>		22d. ADDRESS <div style="text-align: center; font-size: 1.2em;">Boonsboro MD.</div>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">BURIAL</div>		23b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">MAY 1, 1962</div>	
23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">FAIRVIEW CEMETERY</div>		23d. LOCATION (City, town or county) (State) <div style="text-align: center; font-size: 1.2em;">REEDYSVILLE WASH. CO. MD.</div>	
24. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">John W. Best</div>		25a. REC'D BY REGISTRAR <div style="text-align: center; font-size: 1.2em;">DATE MAY 4 '62</div>	
25b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Arthur S. Hume</div>			

MEDICAL CERTIFICATION

This certificate is to be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. JACK BEACHLEY 226 W. WASH. ST.

I

10000

CERTIFICATE OF DEATH

10000

WASHINGTON

WASHINGTON

WACHTOWN

WACHTOWN

3 WEEKS

WASH. CO. Hospital

22 South Potomac St

GRACE-LINNE - HELSER

X

April 21 1901

March 11 1901 at 11

FEMALE WHITE

WATERS

Devon Hotel

Oak Grove Farm D.C.

HELSE

ABRAHAM

HODIE DAE

223 S.W. Ave

See in CHAIRS LEROY HARTMAN

Not

100

100

MAY 1 1901 GREEN COMPTON READING WASH D.C.

Boonsboro Md.

Boonsboro Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05097
05095

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		d. STREET ADDRESS <u>1 509 Beverly Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1962</u>					
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>Sue</u> Last <u>Hemphill</u>				5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>April 3, 1961</u>				9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Hemphill</u>				14. MOTHER'S MAIDEN NAME <u>Ester G. Sheasley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Geo. W. Hemphill</u> Address <u>509 Beverly Lane Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Dilatation</u> 756. } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Post surgical correction of malrotation of intestine</u> <u>marked adhesions</u> (b) <u>4 days.</u> (c) <u>marked adhesions</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>62</u> to <u>1/14</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>1/14</u> , 19 <u>62</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard A. Young</u>				M.D. <u>Richard A. Young</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/16/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>				22d. ADDRESS <u>Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/16/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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James G. Thompson

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05096

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 1/2 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS 148 N. Carlisle St	
3. NAME OF DECEASED (Type or print) First Mary Middle Edith Last Henson		4. DATE OF DEATH Month April Day 30 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1887	
9. AGE (in years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping	
11. BIRTHPLACE (State or foreign country) Washington Co Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Lum		14. MOTHER'S MAIDEN NAME Sarah Atherton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT M. Kenneth N. Henson		Address Greencastle, Pa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subarachnoid hemorrhage (c) arteriosclerotic Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 18 days 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/12 19 62 to 4/30 19 62 that (I) (we) last saw the deceased alive on 4/30/62 , and that death occurred at 5:30 PM from the causes and on the date stated above.			
22a. SIGNATURE W. C. Brewer		22b. DATE SIGNED 5/30/62	
22c. PHYSICIAN'S NAME (Type) W. C. Brewer, M.D.		22d. ADDRESS Greencastle, Pa	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-1962	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harold M. Zimmerman		25. REC'D BY REGISTRAR DATE MAY 7 '62	
ADDRESS Greencastle, Pa		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DESIGN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05099

CERTIFICATE OF DEATH

05097

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY in 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS 551 W. Howard St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Waldo Emerson Hill			4. DATE OF DEATH Month April Day 7 Year 1962		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1894		9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) car inspector		10b. KIND OF BUSINESS OR INDUSTRY railroad	11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David E. Hill			14. MOTHER'S MAIDEN NAME Ida F. Miller		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give year or dates of service) WW I		16. SOCIAL SECURITY NO. WW I	17. INFORMANT Address Mrs. Beulah M. Hill, Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Cardio Vascular Disease DUE TO (c) 15 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Instant
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-1- 1962 , to 4-7- 1962 that (I) (we) last saw the deceased alive on 4-7- 1962 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Dr. E. W. Ditto, Jr.			22b. DATE SIGNED 4-9-62		22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Apr. 10, 62	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.
24 FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.			25a. REC'D BY REGISTRAR APR 11 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hume

VR A15 (4)
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Washington County Hospital

Washington County Hospital

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Scott V. Winick & Son, Washington, Md.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 05099

05101

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>Rd 1 - Greencastle, Pa.</u>	
3. NAME OF DECEASED (Type or print) <u>MICHAEL L. HORSH</u>		4. DATE OF DEATH <u>4/25</u> 19 <u>62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landis Tool Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Opton, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Horsh</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Sheeley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, & (under)) <u>NO</u>		16. SOCIAL SECURITY NO. <u>204-03-5622</u>	
17. INFORMANT <u>Estelle C. Horsh</u>		Address <u>Rd 1 Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis (arteriosclerosis) immediate</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Myocardial infarction syndrome</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July, 1955</u> to <u>Apr. 25, 1962</u> ; that I last saw the deceased alive on <u>Apr. 25, 1962</u> ; and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u> DATE SIGNED <u>Apr 30 '62</u>			
ACTUAL SIGNATURE <u>M. C. Brewer</u> M.D.		DATE SIGNED <u>Apr 30 '62</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Brewer</u>		DATE SIGNED <u>Apr 30 '62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>4/28/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Upton Brothers Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Opton, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u> ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

05102

CERTIFICATE OF DEATH

05100

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
c. LENGTH OF STAY IN 1b 1 Day				d. STREET ADDRESS 1707 Sherman Ave			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY HUFF				4. DATE OF DEATH Month Day Year April 6 1962 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16 1883	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman -Retired		10b. KIND OF BUSINESS OR INDUSTRY C&P Tel. Co		11. BIRTHPLACE (County & State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah Huff				14. MOTHER'S MAIDEN NAME Ella Price			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 212-05-0839		17. INFORMANT Mrs Ola D. Huff			Address 1707 Sherman Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (b) Emphysema DUE TO (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis & nephrosclerosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/7/ , 19 62 , to 4/6 , 19 62 , that (I) (we) last saw the deceased alive on 4/6 , 19 62 , and that death occurred at 4/6 M, from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/6/62	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 136 N. Potomac Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR APR 10 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05:00

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CERTIFICATE OF DEATH

Reg. Dist. No. 05101

05103

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mercersburg, Pa.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D.1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William H. Hunsberger</u>		4. DATE OF DEATH <u>Apr. 13, 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGION</u>	11. BIRTH PLACE (State or foreign country) <u>Washington Co., Ind.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>DAVID HUNSBERGER</u>	
14. MOTHER'S MAIDEN NAME <u>JANE RINGER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>C.W. HUNSBERGER, MERCERSBURG, PA., R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis</u> 4-200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 17, 1955</u> , to <u>Apr 13, 1962</u> , that I last saw the deceased alive on <u>Apr 10, 1962</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		DATE SIGNED <u>4/13/62</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		ADDRESS (Street, city or town, state) <u>Clear Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/15/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BROADFORDING Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington Co., Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kneiss</u>		24a. REC'D BY REGISTRAR <u>APR 16 '62</u>	
ADDRESS <u>Mercersburg, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]		STATE [Faint handwritten state]	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed with the local health officer, who will forward it to the State Department of Health.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05104 CERTIFICATE OF DEATH 05102

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sharpsburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 138 W. Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cora Lucinda Hutson		4. DATE OF DEATH April 30 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 26 1882
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 2 Days 3	
IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James Pierce		14. MOTHER'S MAIDEN NAME Amanda Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Mae Hebb Sharpsburg Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 442X DUE TO Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO Arteriolar-nephro-sclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus.			
INTERVAL BETWEEN ONSET AND DEATH 1 week. 5 years 1 year.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1956, 1962, to May 1, 1962, that (I) (we) last saw the deceased alive on May 1, 1962, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Walter H. Shealy		22b. DATE SIGNED May 2, 1962.	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		22d. ADDRESS Sharpsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 3-62	23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	23d. LOCATION (City, town or county) (State) Sharpsburg Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Maryland		25a. REC'D BY REGISTRAR DATE MAY 4 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Krasa	

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05102

05102

Washington

Maryland

Washington

Page 1000

Shapshap

Washington County Hospital

198 W. Main Street

62

April 30

Butson

Boeing

Gene

Female White

Feb. 28 1882

60 7 2 3

Housewife

House

Maryland

Amelia Baker

James L. Baker

No

none

Mrs. L. H. Hobb Shapshap, Maryland

1 week

Congestive heart failure

3 years

Arteriosclerotic cardiac-vascular disease

1 year

Arteriosclerotic cardiac-vascular disease

Diabetes mellitus

1950

May 1

42

May 2, 1950

Shapshap, Md.

Walter E. Shapshap, M.D.

Shapshap, Maryland

W. E. Shapshap, M.D.

W. E. Shapshap, M.D.

TO FURNISH TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05105 CERTIFICATE OF DEATH 05103

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 9 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 121 East Franklin Street		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 13 Hagerstown d. STREET ADDRESS 121 East Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY DELOSIER JACKSON First Middle Last		4. DATE OF DEATH April 17, 1962 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH February 10, 1882.80. 9. AGE (In years last birthday) 80. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed 11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Maryland. 12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME James K. Delosier		14. MOTHER'S MAIDEN NAME Lydia Clevidence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-34-3897 17. INFORMANT Mrs. Bertha M. Bergum, 124 Randolph Ave. Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertension and arteriosclerotic heart disease DUE TO (b) osteoarthritis DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 10, 1962, to April 17, 1962, that (I) (we) last saw the deceased alive on April 10, 1962, and that death occurred at 5 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 22b. DATE SIGNED 4/17/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/19/62	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown, Maryland.
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Maryland.		25a. REC'D BY REGISTRAR APR 19 '62 25b. REGISTRAR'S SIGNATURE [Signature]	

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FOR STATE
HEALTH DEPT.

TO JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05106 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05104

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clubhouse 3mi. South Of Sharpsburg</u> c. LENGTH OF STAY IN b. <u>State R # 34</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>27 Wayside Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ralph Frederick Keplinger Sr.</u>		4. DATE OF DEATH <u>April 30 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe repair shop Wash. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Keplinger</u>		14. MOTHER'S MAIDEN NAME <u>Anna Mull</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W. W. 1</u>		16. SOCIAL SECURITY NO. <u>214-09-5418</u>	
17. INFORMANT <u>Mrs. Grace Keplinger</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation Carbon Monoxide</u> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Connected hose from exhaust pipe inserted into closed car.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11 4-30- 19 62</u> Hour a.m. <u>11</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R # 34</u>		20f. (City or town) <u>Sharpsburg, Washington, Md.</u> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. W. Ditto, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <u>May 2, 1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-3-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or country) <u>Hagerstown, Md.</u> (State) _____	
23. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

FOR SHIP
NUMBER 001

05108

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JENNIFER ANN		AGE 27		SEX F		RACE W		DATE OF BIRTH 11-11-1980		PLACE OF BIRTH NEW YORK, N.Y.	
RESIDENCE 12345 67th Ave Brooklyn, N.Y. 11234		OCCUPATION Saleswoman		EDUCATION High School		MARRIAGE Married		DATE OF MARRIAGE 05-15-1998		NAME OF SPOUSE JENNIFER ANN	
CAUSE OF DEATH Sudden cardiac death		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial infarction		UNDERLYING CAUSE Coronary artery disease		PREEXISTING DISEASES Hypertension, Diabetes		SIGNS AND SYMPTOMS Chest pain, shortness of breath	
TIME OF DEATH 10:15 AM		DATE OF DEATH 11-11-2000		PLACE OF DEATH Home		WITNESSES John Doe, Jane Smith		SIGNATURE OF MEDICAL EXAMINER [Signature]		DATE OF SIGNATURE 11-11-2000	
FAMILY PHYSICIAN Dr. John Doe		HOSPITAL St. Mary's Hospital		PATHOLOGIST Dr. Jane Smith		LABORATORY City Lab		CORONER John Doe		BURIAL St. Mary's Cemetery	

CERTIFICATE OF DEATH

05107

05105

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CONTY HOSPITAL				d. STREET ADDRESS 1 309 S. POTOMAC ST.			
3. NAME OF DECEASED (Type or print) First TODD Middle DWAYNE Last KESSELRING				4. DATE OF DEATH Month ARRIL Day 12 Year 1962			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1962		9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months 2 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DONALD LOWELL KESSELRING				14. MOTHER'S MAIDEN NAME ANNA DAYMUDE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. DONALD L. KESSELRING		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrops Fetalis DUE TO (b) 77000 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 77000 DUE TO (c) 77000						INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (this hospital) attended the deceased from Apr. 12 , 1962, to Apr. 12 , 1962, that (I) (we) last saw the deceased alive on Apr. 12 , 1962, and that death occurred at 10AM , from the causes and on the date stated above.							
22a. SIGNATURE Harold R. Tritch, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-13-62	
22c. PHYSICIAN'S NAME (Type) Harold R. Tritch, Jr. MD				22d. ADDRESS 302 N. Potomac St Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/13/62		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W.J. Normant, Hagerstown, Md.				25a. REG'D BY REGISTRAR APR 19 '62		25b. REGISTRAR'S SIGNATURE Charles L. Knaus	

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50150

$$\frac{d}{dt} \left(\frac{\partial L}{\partial \dot{x}} \right) = \frac{\partial L}{\partial x}$$

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05108 CERTIFICATE OF DEATH 05106											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegheny Garrett					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 6 Months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				0102-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital						d. STREET ADDRESS 227 Springdale Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle AGNES Last KIMMELL						4. DATE OF DEATH Month 4 Day 4 Year 1962					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 4, 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Garrett, Somerset Co. Pa.				12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Kaiser Kimmel						14. MOTHER'S MAIDEN NAME Emma Wooley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Toledo, Ohio Mrs. Mary Vaillant 4055 Walker Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA BILATERAL DUE TO 332X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) CEREBRAL THROMBOSIS DUE TO 9 MONTHS (c) GENERALIZED ARTERIO SCLEROSIS UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE & CHRONIC PYELONEPHRITIS - DIABETES MELLITUS											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 16, 1961 to April 4, 1962 that (I) (we) last saw the deceased alive on April 4, 1962 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Antonio U. Pallagrosi M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-5-62			
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI						22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/62		23c. NAME OF CEMETERY OR CREMATORY Toledo Memorial Cemetery, Sylvania, Ohio				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman						ADDRESS Hagerstown, Maryland.		25a. REC'D BY REGISTRAR DATE APR 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

(M)

05103

CERTIFICATE OF DEATH

05103

CLARK A. KIMMEL

Age 11-12
Date of Birth
Date of Death
Cause of Death
Place of Death
Signature
Witness
Registrar

05109

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY in 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 443 N. Prospect St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Douglas		First Lee		Middle Kunkle		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH April 2 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack V. Kunkle		14. MOTHER'S MAIDEN NAME Lillian J. Walden					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. J. U. Kunkle 443 N. Prospect St. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Hemorrhage 825X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Cerebral Lacerations (c) Gastric Ulcer With Hemorrhage (d) Pneumonitis		INTERVAL BETWEEN ONSET AND DEATH 3 months 3 months Recent					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. In Auto accident on R# 40 A. 5 mi. East of Hagerstown, Md.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 11-22-31-1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 A. Hagerstown, Washington, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE A. E. W. Ditto, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-3-62			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/62		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 5 '62		24b. REGISTRAR'S SIGNATURE C. L. S. Kunkle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

051110

CERTIFICATE OF DEATH

05108

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>ONE MONTH</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>214 NORTH POTOMAC ST.</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47X-3</u> d. STREET ADDRESS <u>2123 EYE ST. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BLANCHIE B. LAMAR</u> First Middle Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE-30-1895</u> 9. AGE (In years last birthday) <u>66</u> yrs. <u>9</u> Months <u>20</u> Days 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. SENATOR</u> 11. BIRTHPLACE (County & State, or foreign country) <u>BOONSBORO WASH. CO. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ROBERT F. LAMAR</u> 14. MOTHER'S MAIDEN NAME <u>NELLIE EAKLE</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>577-56-9651</u> 17. INFORMANT <u>MRS. ROSS BOWARD</u> Address <u>214 N. POTOMAC ST. HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (U) (this hospital) attended the deceased from <u>26 March, 1962</u> , to <u>20 April, 1962</u> , that (I) (we) last saw the deceased alive on <u>20 April, 1962</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>D. J. [Name]</u>		22b. DATE SIGNED <u>20 April 1962</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APRIL 23, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>APR 25 '62</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

05110

RECORDING OF DEATH

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TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05111
05109
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN H 2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Bartonsville	
3. NAME OF DECEASED (Type or print) First Bertha Middle MAY Last Lare		4. DATE OF DEATH Month April Day 12 , Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Dec 1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 10 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Lare		14. MOTHER'S MAIDEN NAME Annie Barnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Roy E. Lare, Route 1, Knoxville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fractured Right Hip (c) 1 week DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 5 yrs 1 week		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 10 , 19 62 , to April 12 , 19 62 ; that (I) (we) last saw the deceased alive on April 11 , 19 62 , and that death occurred at 5 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE G. W. Hevan		22b. DATE SIGNED 4/12/62 md	
22c. PHYSICIAN'S NAME (Type) G. W. Hevan		22d. ADDRESS Boonsboro	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-14-62	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR APR 16 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

05108

STATE OF TEXAS

05111

Frederick

Harriette

Wesley

Frederick - House 6

2 days

Harriette

Washington County Hospital

Harriette

April 12, 1908

05

10 Dec 1899

White

Female

USA

California

at home

Home-work

Anna's home

Charles H. Jones

Boy N. Lane, House 1, Knoxville, Mo.

Home

No

Frederick, Maryland

George Oliver Gentry

1-11-08

Bertal

M. R. Johnston & Son, Frederick, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE HEALTH DEPT.
M
X
I
2
12
10
VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 62 MADISON AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES FINDLAY LITTLE				4. DATE OF DEATH APRIL 15 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 17 1896	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER COAL COMPANY				11. BIRTHPLACE (State or foreign country) WASHINGTON MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES A LITTLE				14. MOTHER'S MAIDEN NAME SOPHIA FINDLAY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW 1				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT MRS. NANCY KNOWLES				200 E 66th STREET NEW YORK CITY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Descending Colon DUE TO 153.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Diastatic Perforation Of Ascending Colon With (c) DUE TO Acute Generalized Peritonitis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH Recent							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E.W. DITTO JR.				M.D. 4-20-62 DATE SIGNED			
EXAMINER'S NAME (Type) E.W. DITTO JR. M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 215 W WASHINGTON ST HAGERSTOWN MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4-18-62			
22c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY				22d. LOCATION (City, town, or country) (State) WILLIAMSPORT MARYLAND			
23. FUNERAL DIRECTOR Charles H. Houser				24a. REC'D BY REGISTRAR APR 23 '62			
SUPER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND				24b. REGISTRAR'S SIGNATURE Arthur S. Hous			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
051113											
051111											
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN				c. LENGTH OF STAY IN 1b 3 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN				d. STREET ADDRESS 1 335 S. POTOMAC ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GATEWAY NURSING HOME						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle PAULINE Last LONG						4. DATE OF DEATH Month APRIL Day 24 Year 19 62					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/1894		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN H. GRIFFITH						14. MOTHER'S MAIDEN NAME CATHERINE BURGUR					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 220-09-7986		17. INFORMANT MRS. MARGARET BATMAN		Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) general Arteriosclerosis and (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Senility -										INTERVAL BETWEEN ONSET AND DEATH 10 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (the hospital) attended the deceased from Aug 1, 1958 , to Apr 24, 1962 that (I) (we) last saw the deceased alive on Mar 24, 1962 , and that death occurred at 6:16 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Edward W. Ditto, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/25/62			
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto, 111, M.D.						22d. ADDRESS 217 W. Washington ST., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/26/62		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town or county) HAGERSTOWN MD.		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE APR 30 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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CERTIFICATE OF DEATH

01113



George A. Thompson and
Robert A. Thompson

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Robert A. Thompson

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Robert A. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05114 CERTIFICATE OF DEATH 05112

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Garlock Mem. Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>2112 Virginia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA CATHERINE DELLINGER-LONG</u>		4. DATE OF DEATH Month Day Year <u>April 22 1962 19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jany 17 1878</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Downsville Wash Co Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lewis Rhodes</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Forthman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Bertha Dellinger Williamsport Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myelogenous leukemia</u> 204. } DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Atherosclerosis</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1960</u> to <u>Apr. 22, 1962</u> that (II) (we) last saw the deceased alive on <u>Apr. 12, 1962</u> and that death occurred at <u>2 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u> M.D.		22b. DATE SIGNED <u>4-24-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/25/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>APR 26 '62</u> <u>Arthur S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05115

05113

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb 40 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 1 116 MANSE RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BERTHA LOUISE MANN			4. DATE OF DEATH Month APRIL Day 25 Year 19 62				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/1885		9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN BREWER			14. MOTHER'S MAIDEN NAME CATHERINE WINGER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE	17. INFORMANT MR. CARL M. MANN HAGERSTOWN MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 153.2 DUE TO Concussion of abdomen Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Concussion of decumbent colon INTERVAL BETWEEN ONSET AND DEATH 1 yr ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital), attended the deceased from 24 April, 1962, to 25 April, 1962, that (I) (we) last saw the deceased alive on 25 April, 1962, and that death occurred at 5 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Edwin S. Hoackland M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/27/62			
22c. PHYSICIAN'S NAME (Type) Edwin S. Hoackland		22d. ADDRESS Hagerstown Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/28/62	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.			
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment, Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 30 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kneale			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05116

05114

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 48 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 1 923 MT. AETNA ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LOTTIE MANZELL MARKELL		4. DATE OF DEATH Month Day Year APRIL 7 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 29 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BOWERS		14. MOTHER'S MAIDEN NAME IDA McCALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT WILLIAM C MARKELL HAGERSTOWN MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF BLADDER DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 28 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROTIC HEART DISEASE. DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 2-17 , 19 62 to 4-7 , 19 62 ; that (I) (we) last saw the deceased alive on 4-7 , 19 62 , and that death occurred at 11:58 , from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 Pa Ave Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-11-62	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR APR 10 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05117 CERTIFICATE OF DEATH 05115

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA - RURAL</u> c. LENGTH OF STAY IN 1b <u>14 YEARS</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA - RURAL</u> d. STREET ADDRESS <u>Boonsboro MD. R.2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE EDGAR MARTIN</u>		4. DATE OF DEATH <u>APRIL - 16 - 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21 - 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (County & State, or foreign country) <u>REID WASH. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY J. MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE CARPENTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give year or dates of service) <u>W.W. ONE</u>		16. SOCIAL SECURITY NO. <u>MT-18-6603</u>	
17. INFORMANT <u>MRS. BEULAH I. MARTIN</u>		Address <u>Boonsboro MD. R.2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interiselenotic Heart with</u> <u>420.0</u> DUE TO <u>decompensation</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 3, 1962</u> to <u>April 16, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 14, 1962</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G. W. LeVan</u>		22b. DATE SIGNED <u>4/16/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>		22d. ADDRESS <u>Boonsboro, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APRIL 19, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Boonsboro WASH. Co. MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Baird</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u> DATE	
ADDRESS <u>Boonsboro MD</u>		25b. REGISTRAR'S SIGNATURE <u>Clara S. Kraus</u>	

05113

CRIMINAL RECORD

05113

CRIMINAL RECORD

CLARENCE EDGAR MARTIN
 BORN MAY 21 1896
 WHITE
 RETIRED FARMER
 ANNIE CARPENTER
 FARMER

YES W W 21-8-96 MRS. CLARENCE T. MARTIN
 FARMER

J. W. BAKER
 J. W. BAKER
 J. W. BAKER
 J. W. BAKER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05118

05116

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 55 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN RURAL d. STREET ADDRESS HAGERSTOWN RT.#3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERBERT WILLIAM McELWEE		4. DATE OF DEATH Month APRIL Day 26 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1887
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74	IF UNDER 24 HRS. Hours 74 Min. 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PREIDENT& OWNER		10b. KIND OF BUSINESS OR INDUSTRY DAIRY PRODUCTS CO. VIRGINIA	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC R. McELWEE		14. MOTHER'S MAIDEN NAME MARY BREWER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-9640	
17. INFORMANT MRS. RUTH B. McELWEE Address RT.#3 HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to immediate cause (b) Coronary artery disease with angina (c) Indefinite		INTERVAL BETWEEN ONSET AND DEATH 24 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 25, 1941 , to April 26, 1962 , that (I) (we) last saw the deceased alive on April 26, 1962 , and that death occurred at 4:20 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley M.D.		22b. DATE SIGNED April 27, 1962	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 4/29/62	23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEM.	23d. LOCATION (City, town or county) SMITHSBURG MD. (State)
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 2 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hance	

05113

11

05113

EXHIBIT 10

Coronary artery disease with angina

05113

05

05

D. J. Kostelny, M.D.

[Handwritten signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
\$M 2/57

FOR STATE
HEALTH DEPT.

(M)

(I)

2

pp

VS. A15ME
\$M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05119

Reg. Dist. No. 05117

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>03</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>151 WEST WASHINGTON ST.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>151 WEST WASHINGTON ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT EDWARD MORRISON</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 22, 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER-10-1923</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC - FARM IMPLEMENT CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRED N. MORRISON</u>		14. MOTHER'S MAIDEN NAME <u>EDNA R. JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>215-20-8942</u>	
17. INFORMANT <u>FRED N. MORRISON</u>		Address <u>MIDDLEBORG MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation (By Smoke)</u> DUE TO <u>9160</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2nd. And 3rd. Degree Burns Involving Entire Body.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found on bed, mattress completely burned.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11</u> <u>4-22-</u> <u>1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 25 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baer</u>		ADDRESS <u>BOONSBORO MD</u>	
24a. REC'D BY REGISTRAR <u>APR 27 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05120				Items 8 & 9 Film 512 5/7/62 ink				05118			
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash County Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 800 Northern Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HAMILTON MORROW						4. DATE OF DEATH Month Day Year April 10 1962 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1894 Dec 10/1893/		9. AGE (In years last birthday) 67 3/4 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY Retired				11. BIRTHPLACE (Country & State or foreign country) W. Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ruthvan W. Morrow						14. MOTHER'S MAIDEN NAME Lillie M. Muse					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW # 1 214-09-9634		17. INFORMANT Miss Josephene Morrow				Address Md. 800 Northern Ave Hagerstown	
18. CAUSE OF DEATH (Only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Agranulocytic Leukemia 204-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1962		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1962 to April 10, 1962 that (I) (we) last saw the deceased alive on April 10, 1962 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 215 W. Washington St., Hagerstown, Md.				22b. DATE SIGNED April 11, 1962	
22c. PHYSICIAN'S NAME (Type) Dr. E.W. Ditto, Jr.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/13/62		23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		23d. LOCATION (City, town or county) (State) Shepherdstown Jefferson 6 W. Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman						ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR APR 13 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

02118

CERTIFICATE OF MARRIAGE

02120

Blank certificate form with faint, mirrored text visible through the paper. The text is illegible due to the quality of the scan and the nature of the document.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

05121
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05119
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u>	
c. LENGTH OF STAY IN IT <u>4 yrs-1 mos.</u>		d. STREET ADDRESS <u>Route #3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillie E. Myers</u>		4. DATE OF DEATH <u>April 12 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 27 1873</u> (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Berkley Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Jacob T McQuilkin</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Whiting</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>J. Howard Myers</u>	
17. INFORMANT <u>son</u>		Address <u>Charleston, W. Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420-1 DUE TO (b) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour e.m. p.m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>62</u> , to <u>April 12</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>April 12</u> , 19 <u>62</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>M. E. By-Kit</u> M.D.		22b. DATE SIGNED <u>4-12-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. By-Kit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-14-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Martinsburg, West Va.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. K. Brown</u>		ADDRESS <u>Martinsburg, W. Va.</u>	
25a. REC'D BY REGISTRAR <u>APR 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

05119

THE TRUTH OF DEATH

1911

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W. H. H. H.

05128

MEDICAL EXAMINATION REPORT

05128

THE
REPORT
OF
THE
MEDICAL
EXAMINER

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINEE

AGE OF EXAMINEE

SEX OF EXAMINEE

EDUCATION OF EXAMINEE

OCCUPATION OF EXAMINEE

RELIGION OF EXAMINEE

ETHNICITY OF EXAMINEE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
05123											
CERTIFICATE OF DEATH											
Reg. Dist. No. 05121											
1. PLACE OF DEATH a. COUNTY Wash. MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Pa. b. COUNTY Franklin					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown						c. LENGTH OF STAY IN 1b 2 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home						d. STREET ADDRESS 241 S. Allison St					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Mae First J. Middle Pentz Last						4. DATE OF DEATH April 15 1962					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1874		9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Huntingdon Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas McKelvey						14. MOTHER'S MAIDEN NAME Alice Hicks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. No		17. INFORMANT Stanley Pentz - Address Greencastle, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Carcinoma of Breast. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr. 12, 1962 to Apr. 15, 1962, that I last saw the deceased alive on Apr. 14, 1962, and that death occurred at 9 A. M. from the causes and on the date stated above. ACTUAL SIGNATURE David R. Brewer M.D. DATE SIGNED Clear Spring Md 4/17/62 PHYSICIAN'S NAME (Type) David R. Brewer											
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 4/18/62		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill				22d. LOCATION (City, town, or county) (State) Greencastle, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE A.E. Monnich - Greencastle, Pa.						24a. REC'D BY REGISTRAR DATE APR 19 '62		24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1913

NAME OF DECEASED		SEX		AGE	
John Doe		Male		45	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
123 Main St, Baltimore, Md		Jan 15, 1913		Home	
CAUSE OF DEATH		MANNER OF DEATH		OCCASION OF DEATH	
Heart Disease		Natural		Ordinary	
DISEASE		SYMPTOMS		TREATMENT	
Myocardial Infarction		Chest pain, shortness of breath		None	
PREVIOUS ILLNESS		DATE OF BIRTH		DATE OF MARRIAGE	
None		Jan 1, 1868		Jan 1, 1900	
EDUCATION		OCCUPATION		RELIGION	
High School		Clerk		Roman Catholic	
MILITARY SERVICE		NAVY SERVICE		ARMY SERVICE	
None		None		None	
SIGNED		DATE		PLACE	
John Doe, Jr.		Jan 15, 1913		Baltimore, Md	
WITNESSES		DATE		PLACE	
John Doe, Sr.		Jan 15, 1913		Baltimore, Md	
Mary Doe		Jan 15, 1913		Baltimore, Md	
J. Edgar Hoover		Jan 15, 1913		Baltimore, Md	
DATE OF REGISTRATION		PLACE OF REGISTRATION		OFFICE	
Jan 15, 1913		Baltimore, Md		City and County	

REGISTERED COPY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05124 CERTIFICATE OF DEATH 05122											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>				c. LENGTH OF STAY in lb <u>6 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>				d. STREET ADDRESS <u>417 Brewer Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gateway Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edward Clayton Porter</u>						4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 62</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1881</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron works</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Metal worker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bendersville Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Elmer Porter</u>						14. MOTHER'S MAIDEN NAME <u>Catherine Petrs</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-3283A</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Virginia A. Syncire 417 Brewer Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>5 yrs.</u> (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1, 1962</u> to <u>April 22, 1962</u> ; that (I) (we) last saw the deceased alive on <u>April 21, 1962</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>David R. Brewer M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/23/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>						22d. ADDRESS <u>Clear Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>						ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 26 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

05128

CHURCH OF THE

05128

Washington

Washington

Washington

Local Highway

8 mi.

Local Highway

415 Canal Rd.

Washington Highway

05

05

Local

Local

Local Highway

18

April 18, 1881

Local Highway

051

Local Highway

Local Highway

Local Highway

Catharine River

Catharine River

Washington, D.C.

217-10-1281 Washington, D.C.

05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05125

05123

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 45 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 19 W. Magnolia Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Cassandra Potterfield		4. DATE OF DEATH April 5 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1911
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Sidney Ellis		14. MOTHER'S MAIDEN NAME Lulu Forney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No ---		16. SOCIAL SECURITY NO. 214-09-2764	
17. INFORMANT Charles Potterfield		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 330X (b) Rupture of aneurysm of left vertebral artery DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 39 hours 39 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (XXXXXX) attended the deceased from Apr. 3 1962 to Apr. 5 1962 , that (I) (we) last saw the deceased alive on Apr. 5 1962 , and that death occurred at 2:45 pm from the causes and on the date stated above.			
22a. SIGNATURE William T. Layman, M.D.		22b. DATE SIGNED 4-6-62	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 5 Public Square Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-8-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR APR 9 '62	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Knease	

(M)

05153

05153

12 S. Lincoln Ave

Washington County Hospital

Washington

Washington

City

May 10, 1917

White

Washington, D.C.

San Home

Home

White

White

Washington County Hospital

Washington County Hospital

Picture of mother of left ventricle

Picture

Page

APR 3 1917

APR 3 1917

A-1-10

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Scott E. Minnich & Son, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05126

05124

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b. 6 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 019 W WASHINGTON FRANKLIN WSW HAGERSTOWN MD d. STREET ADDRESS 919 W FRANKLIN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle MARIE Last RAIFSNIDER		4. DATE OF DEATH Month APRIL Day 30 Year 19 62	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 6 1900
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESCLERK		10b. KIND OF BUSINESS OR INDUSTRY DEP'T STORE	11. BIRTHPLACE (County & State, or foreign country) MANSFIELD OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MILFORD J BOUGHTON	
14. MOTHER'S MAIDEN NAME EDNA BELL ROGERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 217-10-3270		17. INFORMANT HARVEY E RAIFSNIDER HAGERSTOWN MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Carcinoma Cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma Cervix (c) Carcinoma Breast		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma Breast		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 16 March 1962 to 30 April 1962 that (I) (we) last saw the deceased alive on 30 April 1962 and that death occurred at 10 AM, from the causes and on the date stated above.			
22a. SIGNATURE Frank E Brumbach M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 170 W WASHINGTON ST. HAGERSTOWN MARYLAND	
22c. PHYSICIAN'S NAME (Type) FRANK E BRUMBACK M. D.		22b. DATE SIGNED 1 May 62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-2-62	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE SUTER-ROUZER FUNERAL HOME		25a. REC'D BY REGISTRAR DATE MAY 3 '62	
ADDRESS HAGERSTOWN MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

25120



0095 à 7007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05127
CERTIFICATE OF DEATH
05125

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN TB <u>3 HOURS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>81 WASH. Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X APPLETON RURAL</u> d. STREET ADDRESS <u>1 BOONSBORO MD. R. 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANI DIANE REED</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 15. 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 20 - 1958</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>7 25</u>	11. IF UNDER 24 HRS. Hours Min. <u>2 1/2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. Co. MD.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL REED</u>		14. MOTHER'S MAIDEN NAME <u>ELAINE DE WITT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DANIEL REED</u>		Address <u>BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> 744.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral basal pneumonia</u> DUE TO (c) <u>Mycobacterium granis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u> <u>24 hours</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1962</u> to <u>4/15, 1962</u> that (I) (we) last saw the deceased alive on <u>4/15, 1962</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George Jennings</u>		22b. DATE SIGNED <u>4/17/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>George Jennings</u>		22d. ADDRESS <u>1364 W. Washington St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 18 - 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. Co. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u>	
ADDRESS <u>BOONSBORO MD.</u>		25b. REGISTRAR'S SIGNATURE <u>John S. Kruse</u>	

02127

02125

WASHINGTON

WASHINGTON

CHURCH

ALPHEA TOWN

ROCK

WASH. TO HASTING

BOONSBORO MD R2

JAN DIANE X REED

APRIL 12

WIFE

AUGUST 20 1928 3

5 32

NONE

WASH. CO MD

DANIEL REED ERNINE DE WITTE

WIFE

DANIEL REED BOONSBORO MD R2

Handwritten notes:
Aunt [unclear]
[unclear]
[unclear]

Handwritten notes:
[unclear]
[unclear]
[unclear]

11/2

11/2

11/2

DECEASED

DECEASED

BOONSBORO MD

BOONSBORO MD

1
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05128

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05126

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1369 Marshall St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Cty. Hospital		First Lelia		Middle Caroline		Last Reigh	
3. NAME OF DECEASED (Type or print) Lelia Caroline Reigh		4. DATE OF DEATH April 15 1962		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1925		9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Stouffer's Rest.		11. BIRTHPLACE (State or foreign country) St James Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Luther Wine		14. MOTHER'S MAIDEN NAME Anna Lee Gochenour		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 216-20-9879	
17. INFORMANT Donald Reigh		Address 1369 Marshall St Hagerstown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Comminuted Basilar Skull Fracture DUE TO Compounded Through Cribriform Plate & Ethmoid Sinus (b) Lepto Meningitis Acute DUE TO Cerebral Congestion & Edema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 12 days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Passenger in Taxi that collided with a truck.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Street		20c. TIME OF INJURY Month, Day, Year 7:45 - 4-3- 19 62	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work <input type="checkbox"/> et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown, Washington, Md.		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		22. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md.		22c. DATE THEREOF 4/17/62	
23. FUNERAL DIRECTOR Andrew K. Coffman, Hagerstown, Md.		24a. REG. BY REGISTRAR APR 18 1962		24b. REGISTRAR'S SIGNATURE Charles L. Fennell		DATE April 16, 1962	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05129 CERTIFICATE OF DEATH 05127											
1. PLACE OF DEATH a. COUNTY <u>Adelphi</u> <u>Washington</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr, George's</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY in lb <u>9 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills, Maryland</u> <u>1617-2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mockwood Western Maryland State Hospital</u>						d. STREET ADDRESS <u>5545- Selby Lane S.E.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAURA</u> <u>ALICE</u> <u>RICHARDS</u>						4. DATE OF DEATH <u>APRIL</u> <u>6</u> <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>August 3rd 1901</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Whittaker</u>						14. MOTHER'S MAIDEN NAME <u>Laura Whittaker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Pauline L. Poole</u> <u>Same as # 2.</u> <u>Dau.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATOID ARTHRITIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>FEW MINUTES</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-18-</u> <u>1961</u> , to <u>4-6-</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>4-6-</u> <u>1962</u> , and that death occurred at <u>1:45</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Antonio U. Pellaaron</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>						22d. ADDRESS <u>1500 Pa Ave Hagerstown</u>					
23a. BURIAL, CREMATION, or other (Specify)		23b. DATE THEREOF <u>April 11th 62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Oxon Hill, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>				ADDRESS <u>1661- Good Hope Rd. SE</u> <u>Washington, DC</u>		25a. REC'D BY REGISTRAR DATE <u>APR 9 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

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TO BE FILED WITHIN 24 HOURS AFTER DEATH. The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05130						05128					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Washington			a. STATE			b. COUNTY		
			MARYLAND			Maryland			Washington		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Wevorton			Life			Wevorton			d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)									a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
Annie O. Rickards						4 6 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White				8-18-1880		81 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Housewife				Home				Maryland			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Joshua Okler						Sarah Creuse					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
						Mrs. Edith Kolbaugh, Knoxville, Md.					
17. INFORMANT						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Pulmonary Edema					
4 22 1						3 7 10					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Myocardial Infarction					
						(c) Advanced Cardiovascular Disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						Chronic Nephritis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Jan 4, 1962, to April 6, 1962, that (I) (we) last saw the deceased alive on April 4, 1962, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
A. T. BRICE						APR 10 1962					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
A. T. BRICE						Jefferson Hwy					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			4-8-1962			St. Luke's Episcopal Cem.			Brownsville, Md		
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR					
B. H. Field						25b. REGISTRAR'S SIGNATURE					
Brunswick, Maryland						Arthur S. Rouse					
						DATE APR 10 '62					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05131 CERTIFICATE OF DEATH 05129

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>70 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>308 N. CANNON AVE.</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>330 N. MULBERRY ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>LORETTA</u> Last <u>ROHRER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/2/1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN LONG</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH BARTON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>220-28-8872</u>		17. INFORMANT <u>MR. WILLIAM H. ROHRER</u> Address <u>HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>4500</u> (e), stating the underlying cause last. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Fracture Colles, right of about six weeks duration</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>12</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2-21-61</u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>at home</u> , to <u>death</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4-17-62</u> , and that death occurred <u>2:10 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert F. Keadle</u> Paul Harrison By Robert F. Keadle		22b. DATE SIGNED <u>4-19-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>		22d. ADDRESS <u>Hagerstown Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/20/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM</u>		23d. LOCATION (City, town or county) <u>HAGERSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norman, Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>		25c. REGISTRAR'S NAME <u>Charles S. Harris</u>	

05189

05189

STATE OF NEW YORK

IN SENATE
January 11, 1900

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR
1899

ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS
1899

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS
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ALBANY: J. B. LIPPINCOTT & CO. PRINTERS
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1899

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS
1899

05132

CERTIFICATE OF DEATH

Reg. Dist. No. 05130

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co., Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Rosenberry</u> Last <u>Rosenberry</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 25, 1927</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Central City, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles William Deneen</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Mae Kirchner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Bertha Logsdon Hyndman, Pa. RD#1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric intestinal hemorrhage</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Alcoholism</u> (b) <u>Alcoholism</u> (c) <u>Alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>year</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 April</u> , 19 <u>62</u> , to <u>16 April</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>15 April</u> , 19 <u>62</u> , and that death occurred at <u>1:54</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elder J. Houchens</u> M.D.		ADDRESS (Street, city or town, state) <u>115 W. Wash St</u>	
PHYSICIAN'S NAME (Type) <u>Elder J. Houchens</u>		DATE SIGNED <u>4/16/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 19, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Lueger</u>		ADDRESS <u>Hyndman, Pa.</u>	
24a. REC'D BY REGISTRAR <u>APR 19 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Item 8 Film 0311 4/25/62 mh

05131

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 10 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 423 N. MULBERRY ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last SAMPEL		4. DATE OF DEATH Month APRIL Day 17 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/88
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 17	11. IF UNDER 24 HRS. Hours 17 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY MYERS		14. MOTHER'S MAIDEN NAME ANNIE WOLF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. REGINALD F. SAMPEL		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO (b) Cerebral vascular accident DUE TO (c) Arteriosclerosis Gen. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 16, 1962 to Apr 17, 1962 that (I) last saw the deceased alive on Apr 16, 1962 and that death occurred at 11:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Louis S. Traut		22b. DATE SIGNED 4/17/62	
22c. PHYSICIAN'S NAME (Type) Louis GRAFF		22d. ADDRESS 119 E. Antietam	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/19/62	
23c. NAME OF CEMETERY OR CREMATORY BROADFORDING		23d. LOCATION (City, town or county) (State) CHURCH WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		25a. REC'D BY REGISTRAR APR 23 1962	
ADDRESS Hagerstown, Md		25b. REGISTRAR'S SIGNATURE Arthur S. Traut	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1113

STATE OF DEATH

1113

Handwritten notes:
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Handwritten notes:
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05134
05132
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 710 W. WASHINGTON ST.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 1 710 W. WASHINGTON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE JOHN SCHMIDT		4. DATE OF DEATH Month APRIL Day 5 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ANTIQUE DEALER OWN BUSINESS		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GOTTLIEB SCHMIDT		14. MOTHER'S MAIDEN NAME SUSAN ANN MAISACK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. HELEN JOHNSON		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 gen'l arteriosclerosis DUE TO (b) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) 4500		INTERVAL BETWEEN ONSET AND DEATH sev. yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/5/62 , 19 at 11:30 PM , that (I) (we) last saw the deceased alive on 4/5/62 , 19 at 11:30 PM , and that death occurred at 4/6/62 , 19 at 11:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks, M. D.		22b. DATE SIGNED 4/6/62	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M. D.		22d. ADDRESS 136 N. Potomac Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/8/62	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 10 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

02133

02133

M

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05135

05133

FOR STATE HEALTH DEPT.

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL WEVERTON c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ROUTE 340 WEVERTON		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND f. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FUNKSTOWN d. STREET ADDRESS 101 EAST MAPLE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BILLY WELLINGTON SHEPLEY		4. DATE OF DEATH Month APRIL Day 15 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 11 1917
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11	11. IF UNDER 24 HRS. Hours 11 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY STATE ROAD COMM.	
11. BIRTHPLACE (State or foreign country) HAGERSTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILBUR WELLINGTON SHEPLEY		14. MOTHER'S MAIDEN NAME MAMIE GOUKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 21710 3017	
17. INFORMANT SHIRLEY M. SHEPLEY		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Thrombotic Occlusions, Anterior Descending And Right Coronary Arteries 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction, Left Ventricle, Old And Recent DUE TO (c) Pulmonary Edema	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 4-20-62 DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 215 W Washington St Address (Street, city, town, or county) HAGERSTOWN MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 21 1962	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	22d. LOCATION (City, town, or country) (State) HAGERSTOWN MARYLAND
23. FUNERAL DIRECTOR Charles M. Rouzeau SUPER-ROUZEAU 305 NORTH POTOMAC STREET HAGERSTOWN MARYLAND		24a. REC'D BY REGISTRAR APR 23 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

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FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05136

05134

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARAMOUNT (RURAL)</u>				c. LENGTH OF STAY IN 1b <u>PARAMOUNT X HAGERSTOWN RD#6</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HAGERSTOWN RD#6 (deed on arrival Hagerstown Hospital)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>M.</u> Last <u>SHUCK</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>23</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 14, 1888</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOLS</u>		11. BIRTHPLACE (State or foreign country) <u>FRANKLIN CO. PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>HARMON L SHUCK</u>				14. MOTHER'S MAIDEN NAME <u>MARY M. BURKETT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-36-3798</u>		17. INFORMANT Address <u>Mrs Mary Shuck Hagerstown RD#6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombotic Occlusion, Anterior Descending Branch</u> 260X DUE TO <u>Of Left Coronary Artery, Recent</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary Atherosclerosis, Generalized</u> DUE TO (c) <u>Diabetes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Recent</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps at his home.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>12:50 P.M.</u> <u>4-23-1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home Hagerstown Rd#6, Washington, Md.</u>	
20f. (City or town) <u>Washington, Md.</u>				20g. (County) <u>Washington</u>			
20h. (State) <u>MD</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <u>April 24, 1962</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u>State Line Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>				22b. DATE THEREOF <u>April 25/1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View</u>	
22d. LOCATION (City, town, or country) <u>State Line Md</u>							
23. FUNERAL DIRECTOR <u>A.E. Minnick</u>				ADDRESS <u>Green castle Pa</u>		24a. REC'D BY REGISTRAR DATE <u>APR 26 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

MEDICAL CERTIFICATION

1950

1950
100-100000

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF MEDICAL EXAMINER
DATE OF EXAMINATION

1. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
2. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
3. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
4. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
5. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
6. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
7. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
8. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
9. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.
10. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
05137						05135						
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)						
a. COUNTY			Washington			a. STATE			b. COUNTY			
			MARYLAND			Maryland			Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Hagerstown			55 years			03 Hagerstown						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?			
104 E. First St.						104 E. First St.			YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. IS RESIDENCE ON A FARM?			
Charles Henry Smith						April 8 1962			YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 28, 1874		87 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				
Watchman				Shoe Factory				Martinsburg, W. Va.				
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						
Phillip Smith						Sarah Jane Henry						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.						
No						214-09-5467a						
17. INFORMANT						Address						
Mrs. Velda Grimes						Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency												
420.0 DUE TO Atherosclerotic Heart Disease												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 2 years												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?												
Carcinoma of Prostate, suspected. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (the doctor) attended the deceased from Apr. 1 1962, to Apr. 8 1962, that (I) (we) last saw the deceased alive on Apr. 7 1962, and that death occurred at 6:15 pm, from the causes and on the date stated above.												
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
William T. Layman, M.D.						4-9-62						
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS						
William T. Layman, M.D.						5 Public Square Hagerstown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)				
Burial		Apr. 10, 62		Rose Hill Cemetery		Hagerstown, Md.						
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Scott F. Minnich & Son Hagerstown, Md.						DATE APR 11 '62			Arthur S. Thomas			

05137

(M)

05135

104 E. First St.
 Hagerstown
 22 years
 Hagerstown
 104 E. First St.

Clarice
 20 years
 104 E. First St.
 Hagerstown
 20 years

William
 20 years
 104 E. First St.
 Hagerstown
 20 years

Coronary Insufficiency
 1 week
 2 years

Sept. 7
 1912
 104 E. First St.
 Hagerstown

William T. Hager, M.D.
 Hagerstown, Md.
 104 E. First St.
 Hagerstown

Scott I. Hinner & Son Hagerstown, Md.

CERTIFICATE OF DEATH

05138

05136

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. c. LENGTH OF STAY IN 1b 38 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland d. STREET ADDRESS 340 Blooms Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jack (no) Stokes				4. DATE OF DEATH Month Day Year April 17 19 62			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24 1900	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Concrete Works		11. BIRTHPLACE (County & State, or foreign country) Williamston, N.C		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Thomas Stokes				14. MOTHER'S MAIDEN NAME Winnie Spruill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-07-7453		17. INFORMANT Miss Fannie Stokes			
				Newark, N.J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE. (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS (b) URÆMIA 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 10-12 DAYS UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 6, 1962 , to April 17, 1962 , that (I) (we) last saw the deceased alive on 17 April 1962 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) Wm. Noel Fender, M. D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 218 N. Potomac St., Hagerstown, Md. 22b. DATE SIGNED 20 April 1962			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-1962		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City, town or county) (State) Williamston, N.C	
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr Hagerstown Md ADDRESS				25a. REC'D BY REGISTRAR APR 23 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

13133

CENTRAL CO. DATA

Washington

Washington

Hagerstown, Md.

Hagerstown, Md.

Washington County Hospital

Washington County Hospital

Book (no)

Book (no)

May 24 1933

May 24 1933

Lawyer

Lawyer

Thomas Brooks

Thomas Brooks

no

no

April 11, 1933

Mr. J. J. Jones, Jr.

Mr. J. J. Jones, Jr.

4-22-1933

4-22-1933

Washington County Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05139

05137

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND. b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL (WOLFESVILLE RD) d. STREET ADDRESS Boonsboro MD. R.2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b 3 WEEKS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. Co. HOSPITAL		f. DATE OF DEATH APRIL - 15, 1962	
3. NAME OF DECEASED (Type or print) DELLA B STONEBERGER		4. DATE OF DEATH APRIL - 15, 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 17-1899
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 1 Days 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) STANLEY VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JAMES ALSHIRE		14. MOTHER'S MAIDEN NAME HESTER 'NO RECORD'	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HARRY W. STONEBERGER SR.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thyroid Storm - 252.0 DUE TO Grave's Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Conf. to heart for ulcer 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1950, to April 15, 1962, that (I) (we) last saw the deceased alive on April 14, 1962, and that death occurred 4 P.M., from the causes and on the date stated above.			
22a. SIGNATURE J. J. Secordari		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI		22d. ADDRESS Boonsboro Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 18, 1962	
23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		23d. LOCATION (City, town or county) (State) BOONSBORO WASH. Co. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John L. East		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

1544473191

02132

DECLARATION OF DEATH

00132

WARYLIND WASHINGTON

Robert (husband) RO

December 1952

DELIA B. STANBROOK

January 1952

own name - STANLEY VIRGINIA

HESTER

ALBERT

YONG

HARRY W. STANBROOK ST. BOWEN MD

CONNINGTON MD

APR 11 1952

APR 11 1952

APR 11 1952

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05140

05138

1. PLACE OF DEATH e. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Pennsylvania</u> b. COUNTY <u>Waynesboro</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> d. STREET ADDRESS <u>235 W. Second St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nettie</u> First Middle Last 4. DATE OF DEATH <u>April 14</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 10, 1869</u> 9. AGE (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Willow Hill, Pennsylvania</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>William W. Stringer</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mr. Clyde Warrick</u> Address <u>231 W. Second St. Waynesboro, PA.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 260X DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Arterio Sclerosis & Myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>Jan. 4, 1962</u> Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Waynesboro, Penna.</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 4, 1962</u> to <u>Jan. 14, 1962</u> . That (I) (we) last saw the deceased alive on <u>Jan. 14, 1962</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Brown</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>B. B. Brown M.D.</u>		22b. ADDRESS <u>Waynesboro, Penna.</u> 22d. DATE SIGNED <u>APR 19 '62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/17/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u> 23d. LOCATION (City, town or county) (State) <u>Waynesboro, Penna.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hume</u> ADDRESS <u>Waynesboro, Penna.</u> 25. REC'D BY REGISTRAR <u>APR 19 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

24559

1
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05141 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05139

1. PLACE OF DEATH a. COUNTY Washington County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE W. Va. b. COUNTY Morgan c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sleepy Creek d. STREET ADDRESS 85X-3			
3. NAME OF DECEASED (Type or print) Isaac S Ray Watson				4. DATE OF DEATH Month April Day 7 Year 1962			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/4/62	
9. AGE (In years last birthday) 2 yrs. 4 Months 4 Days		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Julius H. Watson			
14. MOTHER'S MAIDEN NAME Juanita K. Fox				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Juanita K. Watson Address Sleepy Creek			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Interstitial Pneumonia 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 hours							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE [Signature]				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-7-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/10/62		22c. NAME OF CEMETERY OR CREMATORY Shriver's Cemetery	
23. FUNERAL DIRECTOR Howard J. Shriver Hancock md				22d. LOCATION (City, town, or country) (State) Morgan County, W. Va.		24a. REC'D BY REGISTRAR APR 10 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

MEDICAL CERTIFICATION

2170

100-2141
MAY 1964

(M)

14130

100-2141

Washington County

Baytown

Washington County

Wagon

Wagon

Wagon

Wagon

White

White

None

North Carolina

John H. Wilson

John H. Wilson

None

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05142 CERTIFICATE OF DEATH 05140

1. PLACE OF DEATH e. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Doublesburg</u>	
c. LENGTH OF STAY in 1b <u>6 1/2 years</u>		d. STREET ADDRESS <u>Old Hanover Road.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EIVA Cedonia Watts</u>		4. DATE OF DEATH Month Day Year <u>April 27 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 28, 1869</u>
9. AGE (In years last birthday) <u>92 yrs.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Hamstein Carroll Co. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>B. JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>S. B. BENSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Mrs. MARGIE BRIDGE/Hagerstown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ac. Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interval between onset and death</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/27/62</u> to <u>4/27/62</u> , that (I) (we) last saw the deceased alive on <u>4/27/62</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Ralph Young</u> M.D.		22b. DATE SIGNED <u>4/27/62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/29/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cem.</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. CO. MARYLAND</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Echhardt</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
ADDRESS <u>Owings Mills, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

[Handwritten signatures and dates:]

- [Signature]* 4/27/02
- [Signature]* 4/27/02
- [Signature]* 4/27/02
- [Signature]* 4/27/02

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05143

05141

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1212 Glenwood Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY EARL WEAGLEY SR.</u>		4. DATE OF DEATH <u>April 24, 19 62</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 26, 1892</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Rouzersville, Pennsylvania.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>William Weagley</u> 14. MOTHER'S MAIDEN NAME <u>Ida Kinsel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>217-10-3455</u> 17. INFORMANT <u>Florence M. Sheaffer, 600 1/2 Guilford Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>602X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Nonfunctioning kidney, right; stag-horn calculus right kidney</u> DUE TO <u>Anemia secondary</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>Indefinite</u> <u>Indefinite</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Advanced chronic osteitis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 6, 19 62</u> to <u>April 24, 19 62</u> , that (I) (we) last saw the deceased alive on <u>April 24, 19 62</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Kneisley</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/25/62</u>		22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>			
22d. ADDRESS <u>148 West Washington Street Hagerstown Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/27/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Wetlys Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>GREENSBURG, Pa.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> 25a. REC'D BY REGISTRAR <u>APR 26 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Charles L. Kneisley</u>		25c. NAME OF CEMETERY OR CREMATORY <u>Wetlys Cemetery</u>					

The law requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05143

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15/1/58

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05142

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 22 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 48 McKee Ave		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 48 McKee Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERMAN DAVID WEEKS Sr		4. DATE OF DEATH Month Day Year April 28 1962 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15 1901
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Branch Manager Sealtest Foods		10b. KIND OF BUSINESS OR INDUSTRY Lone Star Calhoun Co	
11. BIRTHPLACE (State or foreign country) So. Car.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Daniel Weeks		14. MOTHER'S MAIDEN NAME Rowena Zeagler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No --		16. SOCIAL SECURITY NO. 214-09-8556	
17. INFORMANT Mrs Beatrice A. Weeks		Address 48 McKee Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Occipital Skull Fracture 900.0 DUE TO Cerebral Contusion, Rt. Frontal And Occipital Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobes DUE TO Subarrachnoid Hemorrhage (c) Aspiration Of Vomitus		INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Fell backwards down stairs at his home.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home	
20c. TIME OF INJURY Month, Day, Year 10:30 p.m. 4-28-62 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/62	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR Andrew K. Coffman		24a. REC'D BY REGISTRAR MAY 2 '62	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO HEALTH OFFICIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05145 CERTIFICATE OF DEATH 05143											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in lb 4 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X rural Smithsburg d. STREET ADDRESS 1 RFD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lydia Elizabeth Wiles						4. DATE OF DEATH 4 22 1962					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1882		9. AGE (In years last birthday) 79 yrs.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian Gerlach						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Roy L. Wiles, RFD 2, Smithsburg, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 592 X DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerotic heart disease								INTERVAL BETWEEN ONSET AND DEATH 3 weeks 5 years			
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 22, 1958 to April 22, 1962 that (I) (we) last saw the deceased alive on April 22, 1962 and that death occurred at 6:05 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Young E. Chun M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 22 1962			
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN						22d. ADDRESS 1500 Penna Ave. Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-24-62		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.						ADDRESS		25a. REC'D BY REGISTRAR APR 26 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05144

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 1 601 W. Franklin Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JEFFERIES Middle ALLEN Last WILLIAMS				4. DATE OF DEATH Month April Day 3 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 31, 1911 50		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft.		11. BIRTHPLACE (State or foreign country) Meridian, Mississippi.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Claude Williams			14. MOTHER'S MAIDEN NAME Ruby Dowdle				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hagerstown, Maryland Mrs. Margaret Williams, 601 W. Franklin St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 9/19.8 Peritonitis following gunshot DUE TO wounds (6) of abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Uremia & Pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 days						INTERVAL BETWEEN ONSET AND DEATH 15 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in abdomen					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3-19 p.m. 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Washington Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. SA 5th 9				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr F W Hitt Jr				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 4/3/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/62		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State) Hagerstown Wash Co Md	
23. FUNERAL DIRECTOR Andrew K. Coffman, Hagerstown, Maryland				24a. REC'D BY REGISTRAR APR 9 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05145											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY in 1b <u>03</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>						d. STREET ADDRESS <u>200 Taylor Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sadie</u> <u>Blanche</u> <u>Wolfe</u>						4. DATE OF DEATH Month Day Year <u>April</u> <u>2</u> <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1884</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Bakersville, Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Davis</u>						14. MOTHER'S MAIDEN NAME <u>Mary Ellen Sellers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. J. E. Pleasant</u> Address <u>R# 4 Hagerstown, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute congestive heart failure</u> (c) <u>Chronic asthma</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>5-6 hrs.</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 1962, and that death occurred at..... AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/2/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wm. Noel Fender, M. D.</u>						22d. ADDRESS <u>218 N. Potomac St., Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/4/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>				23d. LOCATION (City, town or county) <u>Funkstown</u> (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> ADDRESS <u>Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 5 '62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

Wm. G. Hork

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May 7, 1914

Washington, D.C.

Very truly yours,

Wm. L. G. ...

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Washington County

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Washington, D.C.

Very truly yours,

Wm. L. G. ...

Wm. L. G. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05148

CERTIFICATE OF DEATH

05146

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>901 Oak Hill Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL BOSTETTER YOUNG</u>				4. DATE OF DEATH Month Day Year <u>April 14 1962 19</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21 1895</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Properties</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Funkstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A. Young Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bostetter</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W.W.# 1</u>				16. SOCIAL SECURITY NO. <u>219-36-4624</u>		17. INFORMANT Address <u>John B. Young 1141 Hamilton Blvd Hagerstown Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)					
2Dc. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this) hospital attended the deceased from <u>April 10, 1962</u> to <u>April 14, 1962</u> that (I) (we) last saw the deceased alive on <u>April 14, 1962</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/16/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>				22d. ADDRESS <u>214 N. Potomac St. Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/17/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>APR 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

VR A15 (4)
15M 7/61

05118

DEATH CERTIFICATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

05149

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05147

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>866 Dewey Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Knodel</u> Last <u>Zeller Sr.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 31, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor & Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Houses</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Morris, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph H. Zeller</u>		14. MOTHER'S MAIDEN NAME <u>Laura Ann Knodel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>214-34-0002</u>	
17. INFORMANT <u>Mrs. H.K. Zeller</u>		Address <u>866 Dewey Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6</u> , 19 <u>61</u> , to <u>April 18</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 18</u> , 19 <u>62</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22b. DATE SIGNED <u>4/19/62</u>	
22d. ADDRESS <u>214 N. Potomac St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Horst</u>		ADDRESS <u>Hagerstown, Md.</u>	
25a. REC'D BY REGISTRAR <u>APR 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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